SENATE BILL No. 1529

Introduced by Senator Alquist

February 24, 2012

An act to amend Section 100185.5 of the Health and Safety Code, and to amend Sections 14043.2, 14043.65, 14043.75, 14107.11, 14123.05, and 14409 of, to amend, repeal, and add Sections 14043.1, 14043.15, 14043.25, 14043.26, 14043.28, 14043.36, 14043.4, 14043.55, and 14043.7 of, and to add Section 14043.38 to, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1529, as introduced, Alquist. Medi-Cal: providers: fraud.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires an applicant or provider, as defined, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, and requires that the application form for enrollment, the provider agreement, and all attachments or changes shall be signed under penalty of perjury. Existing law authorizes the department, upon receipt of reliable evidence, as described, of fraud or willful misrepresentation by a provider, to, among other things, withhold payment for any goods, services, supplies, or merchandise, or any portion thereof. Existing law prohibits the department from enrolling any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program.

This bill would revise these provisions to require, upon receipt of a credible allegation of fraud against a provider, the provider to be

temporarily placed under payment suspension, unless it is determined there is good cause, as defined, not to suspend the payments or to suspend them only in part. This bill would prohibit the department from enrolling a provider in, or would require the department to terminate the provider from, the Medi-Cal program, if it is discovered that the provider has been terminated under Medicare or under the Medicaid Program or Children's Health Insurance Program in any state, and would provide that a temporary suspension may be lifted if a resolution of an investigation or fraud or abuse occurs, as defined. This bill would require, commencing as specified, the department to conduct a criminal background check and require submission of a set of fingerprints when the department designates a provider as a "high" categorical risk, as specified.

This bill would require the department, commencing as specified and with some exceptions, to collect an application fee for enrollment, revalidation of enrollment, or enrollment at a new location or a change in location in the amount calculated by the federal Centers for Medicare and Medicaid Services. This bill would authorize the department to establish a temporary moratorium on enrollment of providers under specified circumstances. This bill would make other related and conforming changes.

This bill would require, on a quarterly basis, the Department of Justice, and any other law enforcement agency that has accepted referrals for investigation from the department, to report to the department a listing of each referral, stating whether the referral continues to be under investigation and whether it involves a credible allegation of fraud. To the extent that this bill increases the duties of local law enforcement agencies, this bill would create a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 100185.5 of the Health and Safety Code is amended to read:

100185.5. (a) When a letter or order of denial of continued enrollment or suspension of any type or duration, based upon fraud or abuse, or a ~~withholding~~ *suspension* of payments, based upon ~~reliable evidence of fraud or willful misrepresentation,~~ *a credible allegation of fraud* is issued by the department to a provider, the director shall review the evidence supporting the denial of continued enrollment, suspension *of providing services*, or ~~withholding~~ *suspension* of payments. If, in the opinion of the director, the evidence shows a ~~pattern or practice of fraud, abuse, or willful misrepresentation~~ *credible allegation of fraud* that, if replicated in any other health care program administered by the department, could cause either fiscal loss to the state or harm to any participant, the director may deny continued enrollment, *or* suspend, or ~~withhold~~ *suspend* payments to, the provider with respect to those other health care programs. Any denial of continued enrollment, suspension *of providing services*, or ~~withholding~~ *suspension* of payments may be for an indefinite or definite period of time, may be stayed for a period of time, and may be with or without conditions or probation.

(b) The director may deny the application of an applicant or provider to participate in any health care program administered by the department, when, based upon fraud or abuse, the applicant or provider has been denied continued enrollment in, or suspended from, any health care program administered by the department, or has had payments ~~withheld~~ *suspended* based upon ~~reliable evidence~~ *a credible allegation* of fraud ~~or willful misrepresentation in connection with any health care program administered by the department~~, and remains ineligible to participate in the health care program from which the applicant or provider was denied continued enrollment, suspended, or had payments ~~withheld~~ *suspended*.

(c) The director may deny any new or additional application of a provider to participate in any health care program administered by the department if utilization controls including, but not limited to, prior authorization or special claims review pursuant to Sections 51159, 51455, and 51460 of Title 22 of the California Code of

Regulations have been imposed upon that provider by any health care program administered by the department. Applications shall not be denied based solely upon utilization controls imposed upon an entire class or category of providers to which that provider belongs.

(d) Notwithstanding any other ~~provision of~~ law, any provider or applicant ~~who~~ *that* has been denied continued enrollment in, or suspended from, or who has had payments ~~withheld~~ *suspended* in connection with, any health care program administered by the department, or whose application to participate in a health care program administered by the department is denied, pursuant to this section, may appeal that action in accordance with Section 14043.65 of the Welfare and Institutions Code.

(e) For purposes of this section, the following definitions apply:

(1) "Abuse" has the same meaning as that term is defined in Section 14043.1 of the Welfare and Institutions Code.

(2) "Administered by the department" means administered by the State Department of Health *Care* Services or by its agents or contractors on behalf of the State Department of Health *Care* Services.

(3) "Applicant" ~~means any person, individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that applies to the department for enrollment as a provider or participation as a provider in a health care program administered by the department~~ *has the same meaning as that term is defined in Section 14043.1 of the Welfare and Institutions Code*.

(4) "Fraud" has the same meaning as that term is defined in Section 14043.1 of the Welfare and Institutions Code.

(5) "Provider" ~~means any person, individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that provides services, goods, supplies, or merchandise, directly or indirectly, to a person enrolled in a health care program administered by the department~~ *has the same meaning as that term is defined in Section 14043.1 of the Welfare and Institutions Code*.

(6) ~~"Withholding of payments"~~ *"Payment suspension"* means the ~~withholding~~ *suspension* of payments in accordance with Section 14107.11 of the Welfare and Institutions Code.

(f) For purposes of this section, "suspension" includes, but is not limited to, suspensions authorized under Article 1.3 (commencing with Section 14043) or Article 3 (commencing with Section 14123) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(g) For purposes of this section, "health care program administered by the department" includes, but is not limited to, the Medi-Cal program.

SEC. 2. Section 14043.1 of the Welfare and Institutions Code is amended to read:

14043.1. As used in this article:

(a) "Abuse" means either of the following:

(1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state.

(2) Practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid and Medicare programs, the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(b) "Applicant" means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the department for enrollment as a provider in the Medi-Cal program.

(c) "Application or application package" means a completed and signed application form, signed under penalty of perjury or notarized pursuant to Section 14043.25, a disclosure statement, a provider agreement, and all attachments or changes in the form, statement, or agreement.

(d) "Appropriate volume of business" means a volume that is consistent with the information provided in the application and any supplemental information provided by the applicant or provider, and is of a quality and type that would reasonably be

expected based upon the size and type of business operated by the applicant or provider.

(e) "Business address" means the location where an applicant or provider provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary. A post office box or commercial box is not a business address. The business address for the location of a vehicle or vessel owned and operated by an applicant or provider enrolled in the Medi-Cal program and used to provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary shall either be the business address location listed on the provider's application as the location where similar services, goods, supplies, or merchandise would be provided or the applicant's or provider's pay to address.

(f) "Convicted" means any of the following:

(1) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a posttrial motion, an appeal pending, or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(2) A federal, state, or local court has made a finding of guilt against an individual or entity.

(3) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

(g) "Debt due and owing" means 60 days have passed since a notice or demand for repayment of an overpayment or another amount resulting from an audit or examination, for a penalty assessment, or for another amount due to the department was sent to the provider, regardless of whether the provider is an institutional provider or a noninstitutional provider and regardless of whether an appeal is pending.

(h) "Enrolled or enrollment in the Medi-Cal program" means authorized under any processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a Medi-Cal beneficiary.

(i) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could

result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(j) "Location" means a street, city, or rural route address or a site or place within a street, city, or rural route address, and the city, county, state, and nine-digit ZIP Code.

(k) "Not currently enrolled at the location for which the application is submitted" means either of the following:

(1) The provider is changing location and moving to a different location than that for which the provider was issued a provider number.

(2) The provider is adding a business address.

(*l*) (1) "Individual dentist practice" means a dentist licensed by the Dental Board of California enrolled or enrolling in Medi-Cal as an individual provider who is a sole proprietor of his or her practice or is a corporation owned solely by the individual dentist and the only dentist practitioner is the owner. An individual dentist practice may include nondentist allied dental health professionals employed and supervised by the dentist.

(2) "Individual physician practice" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California enrolled or enrolling in Medi-Cal as an individual provider who is sole proprietor of his or her practice or is a corporation owned solely by the individual physician and the only physician practitioner is the owner. An individual physician practice may include nonphysician medical practitioners employed and supervised by the physician.

(m) "Preenrollment period" or "preenrollment" includes the period of time during which an application package for enrollment, continued enrollment, or for the addition of or change in a location is pending.

(n) "Professionally recognized standards of health care" means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This subdivision shall not be

construed to mean that all other treatments meet professionally recognized standards of care.

(o) "Provider" means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of a partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program.

(p) "Resolution of an investigation for fraud or abuse" means there is no documentation to indicate either that a charge or accusation has been filed against the provider and either (1) the investigation has not been active at any time during the previous 12 months or (2) the department has been unable, for a period of 12 months, to contact an investigator or responsible representative of any agency investigating the provider.

~~(p)~~

(q) "Unnecessary or substandard items or services" means those that are either of the following:

(1) Substantially in excess of the provider's usual charges or costs for the items or services.

(2) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, Medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are substantially in excess of the patient's needs, or of a quality that fails to meet professionally recognized standards of health care. The department's determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(A) The professional review organization for the area served by the individual or entity.

(B) State or local licensing or certification authorities.

(C) Fiscal agents or contractors or private insurance companies.

(D) State or local professional societies.

(E) Any other sources deemed appropriate by the department.

(r) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.1 as added by

Section 3 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 3. Section 14043.1 is added to the Welfare and Institutions Code, to read:

14043.1. As used in this article:

(a) "Abuse" means either of the following:

(1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state.

(2) Practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid and Medicare programs, the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(b) "Applicant" means an individual, including an ordering, referring, or prescribing individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the department for enrollment as a provider in the Medi-Cal program.

(c) "Application or application package" means a completed and signed application form, signed under penalty of perjury or notarized pursuant to Section 14043.25, a disclosure statement, a provider agreement, and all attachments or changes in the form, statement, or agreement.

(d) "Appropriate volume of business" means a volume that is consistent with the information provided in the application and any supplemental information provided by the applicant or provider, and is of a quality and type that would reasonably be expected based upon the size and type of business operated by the applicant or provider.

(e) "Business address" means the location where an applicant or provider provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary. A post office box or commercial box is not a business address. The business address for the location of a vehicle or vessel owned and operated by an

applicant or provider enrolled in the Medi-Cal program and used to provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary shall either be the business address location listed on the provider's application as the location where similar services, goods, supplies, or merchandise would be provided or the applicant's or provider's pay to address.

(f) "Convicted" means any of the following:

(1) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a posttrial motion, an appeal pending, or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(2) A federal, state, or local court has made a finding of guilt against an individual or entity.

(3) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

(g) "Debt due and owing" means 60 days have passed since a notice or demand for repayment of an overpayment or another amount resulting from an audit or examination, for a penalty assessment, or for another amount due to the department was sent to the provider, regardless of whether the provider is an institutional provider or a noninstitutional provider and regardless of whether an appeal is pending.

(h) "Enrolled or enrollment in the Medi-Cal program" means authorized under any processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a Medi-Cal beneficiary.

(i) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(j) "Location" means a street, city, or rural route address or a site or place within a street, city, or rural route address, and the city, county, state, and nine-digit ZIP Code.

(k) "Not currently enrolled at the location for which the application is submitted" means either of the following:

(1) The provider is changing location and moving to a different location than that for which the provider was issued a provider number.

(2) The provider is adding a business address.

(*l*) (1) "Individual dentist practice" means a dentist licensed by the Dental Board of California enrolled or enrolling in Medi-Cal as an individual provider who is a sole proprietor of his or her practice or is a corporation owned solely by the individual dentist and the only dentist practitioner is the owner. An individual dentist practice may include nondentist allied dental health professionals employed and supervised by the dentist.

(2) "Individual physician practice" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California enrolled or enrolling in Medi-Cal as an individual provider who is sole proprietor of his or her practice or is a corporation owned solely by the individual physician and the only physician practitioner is the owner. An individual physician practice may include nonphysician medical practitioners employed and supervised by the physician.

(m) "Preenrollment period" or "preenrollment" includes the period of time during which an application package for enrollment, continued enrollment, or for the addition of or change in a location is pending.

(n) "Professionally recognized standards of health care" means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This subdivision shall not be construed to mean that all other treatments meet professionally recognized standards of care.

(o) "Provider" means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of a partnership, group association, corporation, institution, or entity, that provides

services, goods, supplies, or merchandise, directly or indirectly, including all ordering, referring, and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program.

(p) "Resolution of an investigation for fraud or abuse" means there is no documentation to indicate either that a charge or accusation has been filed against the provider and either (1) the investigation has not been active at any time during the previous 12 months or (2) the department has been unable, for a period of 12 months, to contact an investigator or responsible representative of any agency investigating the provider.

(q) "Unnecessary or substandard items or services" means those that are either of the following:

(1) Substantially in excess of the provider's usual charges or costs for the items or services.

(2) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, Medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are substantially in excess of the patient's needs, or of a quality that fails to meet professionally recognized standards of health care. The department's determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(A) The professional review organization for the area served by the individual or entity.

(B) State or local licensing or certification authorities.

(C) Fiscal agents or contractors or private insurance companies.

(D) State or local professional societies.

(E) Any other sources deemed appropriate by the department.

(r) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Sections 455.410 and 455.440 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 4. Section 14043.15 of the Welfare and Institutions Code is amended to read:

14043.15. (a) The department may adopt regulations for certification of each applicant and each provider in the Medi-Cal program. No certification shall be required for natural persons licensed or certificated under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act or the Chiropractic Initiative Act.

(b) (1) An applicant or provider who is a natural person, and is licensed or certificated pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, as defined in subdivision (b) of Section 13401 of the Corporations Code, shall comply with Section 14043.26 and shall be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package submitted and approved pursuant to Section 14043.26, notwithstanding that the applicant or provider meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

(2) A provider enrolled in the Medi-Cal program pursuant to paragraph (1), who has disclosed in the application package for enrollment that the provider's practice includes the rendering of services, goods, supplies, or merchandise solely at one, or at more than one, health facility, as defined in Section 1250 of the Health and Safety Code, or clinic, as defined in Section 1204 of the Health and Safety Code, or medical therapy unit, for purposes of Section 123950 of the Health and Safety Code, or residence of the provider's patient, or office of a physician and surgeon involved in the care and treatment of the provider's patients, shall not be required to enroll at each such health facility, clinic, medical therapy unit, patient's residence or physician and surgeon's office location and may utilize the business addresses listed on the application for enrollment pursuant to paragraph (1) to claim reimbursement from the Medi-Cal program for services rendered by the provider to Medi-Cal beneficiaries at all of those health facilities, clinics, medical therapy units, residences, or physician offices.

(3) This subdivision shall not be interpreted to allow the violation of any state or federal law governing fiscal intermediaries or Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act. This subdivision does not remove the requirement that each claim for reimbursement from the Medi-Cal program identify the place of service and the rendering provider.

(c) An applicant or provider licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of, or a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Division 2 of the Health and Safety Code may be enrolled in the Medi-Cal program as a clinic or a health facility and need not comply with Section 14043.26 if the clinic or health facility is certified by the department to participate in the Medi-Cal program.

(d) An applicant or provider that meets the requirements to qualify as exempt from clinic licensure under subdivisions (b) to (*l*), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206 of the Health and Safety Code shall comply with Section 14043.26 and may be enrolled in the Medi-Cal program as either a clinic or within any other provider category for which the applicant or provider qualifies. An applicant or provider to which any of the clinic licensure exemptions specified in this subdivision apply shall identify the licensure exemption category and document in its application package the legal and factual basis for the clinic license exemption claimed.

(e) Notwithstanding subdivisions (a), (b), (c), and (d), an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and that is operated by a licensed primary care clinic, and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary care clinic operating the applicant, provider clinic, or mobile health

care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.

(f) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.15 as added by Section 5 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 5. Section 14043.15 is added to the Welfare and Institutions Code, to read:

14043.15. (a) The department may adopt regulations for certification of each applicant and each provider in the Medi-Cal program. No certification shall be required for natural persons licensed or certificated under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

(b) (1) An applicant or provider who is a natural person, and is licensed or certificated pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, as defined in subdivision (b) of Section 13401 of the Corporations Code, shall comply with Section 14043.26 and shall be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package submitted and approved pursuant to Section 14043.26, notwithstanding that the applicant or provider meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

(2) A provider enrolled in the Medi-Cal program pursuant to paragraph (1), who has disclosed in the application package for enrollment that the provider's practice includes the rendering of services, goods, supplies, or merchandise solely at one, or at more than one, health facility, as defined in Section 1250 of the Health and Safety Code, or clinic, as defined in Section 1204 of the Health and Safety Code, or medical therapy unit, for purposes of Section 123950 of the Health and Safety Code, or residence of the provider's patient, or office of a physician and surgeon involved in the care and treatment of the provider's patients, shall not be required to enroll at each such health facility, clinic, medical therapy unit, patient's residence or physician and surgeon's office

location and may utilize the business addresses listed on the application for enrollment pursuant to paragraph (1) to claim reimbursement from the Medi-Cal program for services rendered by the provider to Medi-Cal beneficiaries at all of those health facilities, clinics, medical therapy units, residences, or physician offices.

(3) This subdivision shall not be interpreted to allow the violation of any state or federal law governing fiscal intermediaries or Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act. This subdivision does not remove the requirement that each claim for reimbursement from the Medi-Cal program identify the place of service and the rendering, ordering, or prescribing provider.

(c) An applicant or provider licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of, or a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Division 2 of the Health and Safety Code may be enrolled in the Medi-Cal program as a clinic or a health facility and need not comply with Section 14043.26 if the clinic or health facility is certified by the department to participate in the Medi-Cal program.

(d) An applicant or provider that meets the requirements to qualify as exempt from clinic licensure under subdivisions (b) to (*l*), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206 of the Health and Safety Code shall comply with Section 14043.26 and may be enrolled in the Medi-Cal program as either a clinic or within any other provider category for which the applicant or provider qualifies. An applicant or provider to which any of the clinic licensure exemptions specified in this subdivision apply shall identify the licensure exemption category and document in its application package the legal and factual basis for the clinic license exemption claimed.

(e) Notwithstanding subdivisions (a), (b), (c), and (d), an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and that is operated by a licensed primary care

clinic, and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary care clinic operating the applicant, provider clinic, or mobile health care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.

(f) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Sections 455.410 and 455.440 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 6. Section 14043.2 of the Welfare and Institutions Code is amended to read:

14043.2. (a) Whether or not regulations for certification are adopted under Section 14043.15, in order to be enrolled as a provider, or for enrollment as a provider to continue, an applicant or provider may be required to sign a provider agreement and shall disclose all information as required in federal ~~medicaid~~ *Medicaid* regulations and any other information required by the department. Applicants, providers, and persons with an ownership or control interest, as defined in federal ~~medicaid~~ *Medicaid* regulations, shall submit their *date of birth and their* social security number or numbers to the department, to the full extent allowed under federal law. *Corporations with an ownership or control interest, as defined in federal Medicaid regulations, shall submit their taxpayer identification number and all business address locations and post office box addresses.* The director may designate the form of a provider agreement by provider type. Failure to disclose the required information, or the disclosure of false information, shall result in denial of the application for enrollment or shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include ~~temporary~~ deactivation of the provider's number or numbers, including all business addresses

used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify the provider of the temporary suspension and deactivation of the provider's number or numbers, including all business addresses used by the provider, and the effective date thereof. Notwithstanding Section 100171 of the Health and Safety Code and Section 14123, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

SEC. 7. Section 14043.25 of the Welfare and Institutions Code is amended to read:

14043.25. (a) The application form for enrollment, the provider agreement, and all attachments or changes to either, shall be signed under penalty of perjury.

(b) The department may require that the application form for enrollment, the provider agreement, and all attachments or changes to either, submitted by an applicant or provider licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, be notarized.

(c) Application forms for enrollment, provider agreements, and all attachments or changes to either, submitted by an applicant or provider not subject to subdivision (b) shall be notarized. This subdivision shall not apply with respect to providers under the In-Home Supportive Services program.

(d) This section shall become inoperative on the effective date of the state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.25 as added by Section 8 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 8. Section 14043.25 is added to the Welfare and Institutions Code, to read:

14043.25. (a) The application form for enrollment, the provider agreement, and all attachments or changes to either, shall be signed under penalty of perjury.

(b) The department may require that the application form for enrollment, the provider agreement, and all attachments or changes to either, submitted by an applicant or provider licensed pursuant to Division 2 (commencing with Section 500) of the Business and

Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, be notarized.

(c) Application forms for enrollment, provider agreements, and all attachments or changes to either, submitted by an applicant or provider not subject to subdivision (b) shall be notarized. This subdivision shall not apply with respect to providers under the In-Home Supportive Services program.

(d) The department shall collect an application fee for enrollment, revalidation of enrollment, or enrollment at a new location or a change in location. The application fee shall not be collected from individual physicians or nonphysician practitioners, from providers that are enrolled in Medicare another state's Medicaid or Children's Health Insurance program, from providers that submit proof that they have paid the applicable fee to a Medicare contractor or to another state's Medicaid program, or pursuant to an exemption or waiver pursuant to federal law. The application fee collected shall be in the amount calculated by the federal Centers for Medicare and Medicaid Services in effect for the calendar year during which the application for enrollment is received by the department.

(e) (1) This section shall become operative on the effective data of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section, the director shall execute a declaration, to be retained by the director, that states this approval has been obtained and the effective date of the state plan amendment.

SEC. 9. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that currently is not enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or, except as provided in subdivisions (b) and (e), a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for

enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) A physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a dentist licensed by the Dental Board of California, practicing as an individual physician practice or as an individual dentist practice, as defined in Section 14043.1, who is enrolled and in good standing in the Medi-Cal program, and who is changing locations of that individual physician practice or individual dentist practice within the same county, shall be eligible to continue enrollment at the new location by filing a change of location form to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. Filing this form shall be in lieu of submitting a complete application package pursuant to subdivision (a).

(c) (1) Except as provided in paragraph (2), within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that

there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(2) Within 15 days after receiving an application package from a physician, or a group of physicians, licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a change of location form pursuant to subdivision (b), the department shall provide written notice that the application package or the change of location form has been received.

(d) (1) If the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 60 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall ~~issue~~ *enroll* the applicant ~~a provider number~~ or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

(2) Notwithstanding any other provision of law, an applicant or provider who meets all of the following criteria shall be eligible for enrollment in the Medi-Cal program pursuant to this subdivision, after submission and review of a short form application:

(A) The applicant's or provider's practice is based in one or more of the following: a general acute care hospital, a rural general acute care hospital, or an acute psychiatric hospital, as defined in

subdivisions (a) and (b) of Section 1250 of the Health and Safety Code.

(B) The applicant or provider holds a current, unrevoked, or unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the licensee has been placed on probation, or the license is subject to any other limitation.

(C) The applicant or provider does not have an adverse entry in the federal Healthcare Integrity and Protection Data Bank.

(3) An applicant shall be granted provisional provider status under this subdivision for a period of 12 months.

(f) Except as provided in subdivision (g), within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (d), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(g) Notwithstanding subdivision (f), within 90 days after receiving an application package submitted pursuant to subdivision (a) from a physician or physician group licensed by the Medical Board of California or the Osteopathic Medical Board of California, or from the date of the notice to that physician or physician group that does not qualify as a preferred provider under subdivision (d), or within 90 days after receiving a change of location form submitted pursuant to subdivision (b), the department shall give written notice to the applicant or provider that either paragraph (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 91st day.

(h) (1) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is resubmitted with all requested information and documentation, and received by the department within 60 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (f).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall

be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it was approved, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(k) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a), or filed a change of location form pursuant to subdivision (b), may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package or change of location form is approved or denied under this section, and shall not be subject, during that period, to deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(*l*) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(m) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(n) The amendments to subdivision (b), which implement a change of location form, and the addition of paragraph (2) to subdivision (c), the amendments to subdivision (e), and the addition of subdivision (g), which prescribe different processing timeframes for physicians and physician groups, as contained in Chapter 693 of the Statutes of 2007, shall become operative on July 1, 2008.

(o) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.26 as added by Section 10 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 10. Section 14043.26 is added to the Welfare and Institutions Code, to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that currently is not enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or, except as provided in subdivisions (b) and (e), a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) A physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a dentist licensed by the Dental Board of California, practicing as an individual physician practice or as an individual dentist practice, as defined in Section 14043.1, who is enrolled and in good standing in the Medi-Cal program, and who is changing locations of that individual physician practice or individual dentist practice within the same county, shall be eligible to continue enrollment at the new location by filing a change of location form to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. Filing this form shall be in lieu of submitting a complete application package pursuant to subdivision (a).

(c) (1) Except as provided in paragraph (2), within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(2) Within 15 days after receiving an application package from a physician, or a group of physicians, licensed by the Medical

Board of California or the Osteopathic Medical Board of California, or a change of location form pursuant to subdivision (b), the department shall provide written notice that the application package or the change of location form has been received.

(d) (1) If the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 60 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health

and Safety Code) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall enroll the applicant or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

(2) Notwithstanding any other provision of law, an applicant or provider who meets all of the following criteria shall be eligible for enrollment in the Medi-Cal program pursuant to this subdivision, after submission and review of a short form application:

(A) The applicant’s or provider’s practice is based in one or more of the following: a general acute care hospital, a rural general acute care hospital, or an acute psychiatric hospital, as defined in subdivisions (a) and (b) of Section 1250 of the Health and Safety Code.

(B) The applicant or provider holds a current, unrevoked, or unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the

licensee has been placed on probation, or the license is subject to any other limitation.

(C) The applicant or provider does not have an adverse entry in the federal Healthcare Integrity and Protection Data Bank.

(3) An applicant shall be granted provisional provider status under this subdivision for a period of 12 months.

(f) Except as provided in subdivision (g), within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (d), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(E) For failing to submit fingerprints as required by federal Medicaid regulations.

(g) Notwithstanding subdivision (f), within 90 days after receiving an application package submitted pursuant to subdivision (a) from a physician or physician group licensed by the Medical Board of California or the Osteopathic Medical Board of California,

or from the date of the notice to that physician or physician group that does not qualify as a preferred provider under subdivision (d), or within 90 days after receiving a change of location form submitted pursuant to subdivision (b), the department shall give written notice to the applicant or provider that either paragraph (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 91st day.

(h) (1) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is resubmitted with all requested information and documentation, and received by the department within 60 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (f).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a currently enrolled provider as defined in Section 14043.1, including providers applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply

for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a currently enrolled provider as defined in Section 14043.1, including providers applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it was

approved, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(k) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a), or filed a change of location form pursuant to subdivision (b), may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package or change of location form is approved or denied under this section, and shall not be subject, during that period, to deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(*l*) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(m) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has

processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(n) The amendments to subdivision (b), which implement a change of location form, and the addition of paragraph (2) to subdivision (c), the amendments to subdivision (e), and the addition of subdivision (g), which prescribe different processing timeframes for physicians and physician groups, as contained in Chapter 693 of the Statutes of 2007, shall become operative on July 1, 2008.

(o) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Sections 455.434 and 455.450 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 11. Section 14043.28 of the Welfare and Institutions Code is amended to read:

14043.28. (a) (1) If an application package is denied under Section 14043.26 or provisional provider status or preferred provisional provider status is terminated under Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years from the date the application package is denied or the provisional provider status is terminated, except as provided otherwise in paragraph (2) of subdivision (h), or paragraph (2) of subdivision (i), of Section 14043.26 and as set forth in this section.

(2) If the application is denied under paragraph (2) of subdivision (h) of Section 14043.26 because the applicant failed to resubmit an incomplete application package or is denied under paragraph (2) of subdivision (i) of Section 14043.26 because the

applicant failed to remediate discrepancies, the applicant may resubmit an application in accordance with paragraph (2) of subdivision (h) or paragraph (2) of subdivision (i), respectively.

(3) If the denial of the application package is based upon a conviction for any offense or for any act included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon a conviction for any offense or for any act included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of 10 years from the date the application package is denied or the provisional provider status or preferred provisional provider status is terminated.

(4) If the denial of the application package is based upon two or more convictions for any offense or for any two or more acts included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon two or more convictions for any offense or for any two acts included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be permanently barred from enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors.

(5) The prohibition in paragraph (1) against reapplying for three years shall not apply if the denial of the application or termination of provisional provider status or preferred provisional provider status is based upon any of the following:

(A) The grounds provided for in paragraph (4), or subparagraph (B) of paragraph (7), of subdivision (c) of Section 14043.27.

(B) The grounds provided for in subdivision (d) of Section 14043.27, if the investigation is closed without any adverse action being taken.

(C) The grounds provided for in paragraph (6) of subdivision (c) of Section 14043.27. However, the department may deny reimbursement for claims submitted while the provider was noncompliant with CLIA.

(b) (1) If an application package is denied under subparagraph (A), (B), or (D) of paragraph (4) of subdivision (f) of Section

14043.26, or with respect to a provider described in subparagraph (B) of paragraph (2) of subdivision (h), or subparagraph (B) of paragraph (2) of subdivision (i), of Section 14043.26, or provisional provider status or preferred provisional provider status is terminated based upon any of the grounds stated in subparagraph (A) of paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12), inclusive, of subdivision (c) of Section 14043.27, all business addresses of the applicant or provider shall be deactivated and the applicant or provider shall be removed from enrollment in the Medi-Cal program by operation of law.

(2) If the termination of provisional provider status is based upon the grounds stated in subdivision (d) of Section 14043.27 and the investigation is closed without any adverse action being taken, or is based upon the grounds in subparagraph (B) of paragraph (7) of subdivision (c) of Section 14043.27 and the applicant or provider obtains the appropriate license, permits, or approvals covering the period of provisional provider status, the termination taken pursuant to subdivision (c) of Section 14043.27 shall be rescinded, the previously deactivated provider numbers shall be reactivated, and the provider shall be reenrolled in the Medi-Cal program, unless there are other grounds for taking these actions.

(c) Claims that are submitted or caused to be submitted by an applicant or provider who has been suspended from the Medi-Cal program for any reason or who has had its provisional provider status terminated or had its application package for enrollment or continued enrollment denied and all business addresses deactivated may not be paid for services, goods, merchandise, or supplies rendered to Medi-Cal beneficiaries during the period of suspension or termination or after the date all business addresses are deactivated.

(d) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.28 as added by Section 12 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 12. Section 14043.28 is added to the Welfare and Institutions Code, to read:

14043.28. (a) (1) If an application package is denied under Section 14043.26 or provisional provider status or preferred

provisional provider status is terminated under Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years from the date the application package is denied or the provisional provider status is terminated, except as provided otherwise in paragraph (2) of subdivision (h), or paragraph (2) of subdivision (i), of Section 14043.26 and as set forth in this section.

(2) If the application is denied under paragraph (2) of subdivision (h) of Section 14043.26 because the applicant failed to resubmit an incomplete application package or is denied under paragraph (2) of subdivision (i) of Section 14043.26 because the applicant failed to remediate discrepancies, the applicant may resubmit an application in accordance with paragraph (2) of subdivision (h) or paragraph (2) of subdivision (i), respectively.

(3) If the denial of the application package is based upon a conviction for any offense or for any act included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon a conviction for any offense or for any act included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of 10 years from the date the application package is denied or the provisional provider status or preferred provisional provider status is terminated.

(4) If the denial of the application package is based upon two or more convictions for any offense or for any two or more acts included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon two or more convictions for any offense or for any two acts included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be permanently barred from enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors.

(5) The prohibition in paragraph (1) against reapplying for three years shall not apply if the denial of the application or termination

of provisional provider status or preferred provisional provider status is based upon any of the following:

(A) The grounds provided for in paragraph (4), or subparagraph (B) of paragraph (7), of subdivision (c) of Section 14043.27.

(B) The grounds provided for in subdivision (d) of Section 14043.27, if the investigation is closed without any adverse action being taken.

(C) The grounds provided for in paragraph (6) of subdivision (c) of Section 14043.27. However, the department may deny reimbursement for claims submitted while the provider was noncompliant with CLIA.

(b) (1) If an application package is denied under subparagraph (A), (B), (D), or (E) of paragraph (4) of subdivision (f) of Section 14043.26, or with respect to a provider described in subparagraph (B) of paragraph (2) of subdivision (h), or subparagraph (B) of paragraph (2) of subdivision (i), of Section 14043.26, or provisional provider status or preferred provisional provider status is terminated based upon any of the grounds stated in subparagraph (A) of paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12), inclusive, of subdivision (c) of Section 14043.27, all business addresses of the applicant or provider shall be deactivated and the applicant or provider shall be removed from enrollment in the Medi-Cal program by operation of law.

(2) If the termination of provisional provider status is based upon the grounds stated in subdivision (d) of Section 14043.27 and the investigation is closed without any adverse action being taken, or is based upon the grounds in subparagraph (B) of paragraph (7) of subdivision (c) of Section 14043.27 and the applicant or provider obtains the appropriate license, permits, or approvals covering the period of provisional provider status, the termination taken pursuant to subdivision (c) of Section 14043.27 shall be rescinded, the previously deactivated provider numbers shall be reactivated, and the provider shall be reenrolled in the Medi-Cal program, unless there are other grounds for taking these actions.

(c) Claims that are submitted or caused to be submitted by an applicant or provider who has been suspended from the Medi-Cal program for any reason or who has had its provisional provider status terminated or had its application package for enrollment or continued enrollment denied and all business addresses deactivated

may not be paid for services, goods, merchandise, or supplies rendered to Medi-Cal beneficiaries during the period of suspension or termination or after the date all business addresses are deactivated.

(d) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Sections 455.434 and 455.450 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 13. Section 14043.36 of the Welfare and Institutions Code is amended to read:

14043.36. (a) The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider’s number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify in writing the provider of the temporary suspension and deactivation of the provider's number, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

(c) A temporary suspension may be lifted when a resolution of an investigation for fraud or abuse occurs.

(d) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.36 as added by Section 14 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 14. Section 14043.36 is added to the Welfare and Institutions Code, to read:

14043.36. (a) The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program.

(b) If it is discovered that a provider has been terminated under Medicare or under the Medicaid Program or Children's Health Insurance Program in any state, the provider shall not be enrolled in, or shall be subject to termination from, the Medi-Cal program, which shall include deactivation of the provider's enrolled numbers and all business addresses used to obtain reimbursement from the Medi-Cal program.

(c) The director shall notify in writing the provider of the temporary suspension and deactivation of the provider's number, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

(d) A temporary suspension may be lifted when a resolution of an investigation for fraud or abuse occurs.

(e) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Section 455.416 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 15. Section 14043.38 is added to the Welfare and Institutions Code, to read:

14043.38. (a) If the department designates a provider as a "high" categorical risk, the department shall conduct a criminal background check and shall require submission of a set of fingerprints in accordance with Section 13000 of the Penal Code. If fingerprints are required, providers and any person with a 5-percent direct or indirect ownership interest in the provider shall be required to submit fingerprints in a manner determined by the department within 30 days of the request.

(b) In designating a provider's categorical risk, the department may utilize the "high" categorical risk provider types designated in Section 424.518 of Title 42 of the Code of Federal Regulations.

(c) In accordance with Section 455.450 of Title 42 of the Code of Federal Regulations, the department shall designate a provider as a "high" categorical risk if any of the following occur:

(1) The department imposes a payment suspension based on a credible allegation of fraud, waste, or abuse.

(2) The provider has an existing Medicaid overpayment.

(3) The provider has been excluded by the federal Office of the Inspector General or another state's Medicaid program within the previous 10 years.

(4) The federal Centers for Medicare and Medicaid Services lifted a temporary moratorium within the previous six months for the particular provider type submitting the application, the applicant would have been prevented from enrolling based on that previous moratorium, and the applicant applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

(d) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Sections 424.518, 455.434, and 455.450 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 16. Section 14043.4 of the Welfare and Institutions Code is amended to read:

14043.4. *(a)* If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure to remediate discrepancies as prescribed by the director may result in denial of the application for enrollment.

(b) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.4 as added by Section 17 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 17. Section 14043.4 is added to the Welfare and Institutions Code, to read:

14043.4. (a) If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure of a provider to remediate discrepancies as prescribed by the director may result in denial of the application for enrollment and deactivation of all of the provider's business addresses.

(b) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Section 455.416 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 18. Section 14043.55 of the Welfare and Institutions Code is amended to read:

14043.55. *(a)* The department may implement a 180-day moratorium on the enrollment of providers in a specific provider of service category, on a statewide basis or within a geographic area, except that no moratorium shall be implemented on the enrollment of providers who are licensed as clinics under Section 1204 of the Health and Safety Code, health facilities under Chapter 2 (commencing with Section 1250) of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, or natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. This moratorium may be extended or repeated when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in Section 14105.3.

(b) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.55 as added

by Section 19 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 19. Section 14043.55 is added to the Welfare and Institutions Code, to read:

14043.55. (a) The department may implement a 180-day moratorium on the enrollment of providers in a specific provider of service category, on a statewide basis or within a geographic area, except that no moratorium shall be implemented on the enrollment of providers who are licensed as clinics under Section 1204 of the Health and Safety Code, health facilities under Chapter 2 (commencing with Section 1250) of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, or natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. This moratorium may be extended or repeated when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in Section 14105.3.

(b) If the Secretary of the United States Department of Health and Human Services establishes a temporary moratorium on enrollment as described in federal regulations, the department shall establish a corresponding moratorium covering the same period and provider types, even if those provider types would not ordinarily be subject to a moratorium under this section, unless the department determines that the imposition of the moratorium will adversely impact beneficiaries access to medical assistance. A moratorium adopted under this subdivision shall not be subject to any of the determinations or prerequisites required of a state-initiated moratorium.

(c) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Section 455.470 of Title 42 of the

Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 20. Section 14043.65 of the Welfare and Institutions Code is amended to read:

14043.65. (a) Notwithstanding any other ~~provision of~~ law, any applicant whose application for enrollment as a provider or whose certification is denied; or any provider who is denied continued enrollment or certification, or denied enrollment for a new location, who has been temporarily suspended, who has had payments ~~withheld~~ *suspended*, who has had one or more business addresses used to obtain reimbursement from the Medi-Cal program deactivated, or whose provisional provider status or preferred provisional provider status has been terminated pursuant to this article or Section 14107.11, or Section 100185.5 of the Health and Safety Code, or who has had a civil penalty imposed pursuant to subdivision (a) of Section 14123.25; or any billing agent, as defined in Section 14040, when the billing agent's registration has been denied pursuant to subdivision (e) of Section 14040.5, may appeal this action by submitting a written appeal, including any supporting evidence, to the director or the director's designee. ~~Where~~ *If* the appeal is of a ~~withholding~~ *suspension* of payment pursuant to Section 14107.11, the appeal to the director or the director's designee shall be limited to the issue of the reliability of the evidence supporting the ~~withhold~~ *payment suspension* and shall not encompass fraud or abuse. The appeal procedure shall not include a formal administrative hearing under the Administrative Procedure Act and shall not result in reactivation of any deactivated provider numbers during appeal. An applicant, provider, or billing agent that files an appeal pursuant to this section shall submit the written appeal along with all pertinent documents and all other relevant evidence to the director or to the director's designee within 60 days of the date of notification of the department's action. The director or the director's designee shall review all of the relevant materials submitted and shall issue a decision within 90 days of the receipt of the appeal. The decision may provide that the action taken should be upheld, continued, or reversed, in whole or in part. The decision of the director or the director's designee shall be final.

Any further appeal shall be required to be filed in accordance with Section 1085 of the Code of Civil Procedure.

(b) No applicant whose application for enrollment as a provider has been denied pursuant to Section 14043.2, 14043.36, or 14043.4 may reapply for a period of three years from the date the application is denied. The three-year period shall commence upon the date of the denial notice.

SEC. 21. Section 14043.7 of the Welfare and Institutions Code is amended to read:

14043.7. (a) The department may make unannounced visits to any applicant or to any provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. At the time of the visit, the applicant or provider shall be required to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as relevant to his or her scope of practice, as indicated by, but not limited to, the following:

(1) Being open and available to the general public.

(2) Having regularly established and posted business hours.

(3) Having adequate supplies in stock on the premises.

(4) Meeting all local laws and ordinances regarding business licensing and operations.

(5) Having the necessary equipment and facilities to carry out day-to-day business for his or her practice.

(b) An unannounced visit pursuant to subdivision (a) shall be prohibited with respect to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless the department has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

(c) Failure to remediate significant discrepancies in information provided to the department by the provider or significant discrepancies that are discovered as a result of an announced or

unannounced visit to a provider, for purposes of enrollment, continued enrollment, or certification pursuant to subdivision (a) shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program. The director shall notify in writing the provider of the temporary suspension and deactivation of provider numbers, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions in this paragraph shall be in accordance with Section 14043.65.

(d) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.7 as added by Section 22 of the act that added this subdivision, and is repealed on the January 1 of the following year.

SEC. 22. Section 14043.7 is added to the Welfare and Institutions Code, to read:

14043.7. (a) The department may make unannounced visits to any applicant or to any provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. If an unannounced site visit is conducted by the department for any enrolled provider, the provider shall permit access to any and all of their provider locations. If a provider fails to permit access for any site visit, the application shall be denied and the provider shall be subject to deactivation. At the time of the visit, the applicant or provider shall be required to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as relevant to his or her scope of practice, as indicated by, but not limited to, the following:

(1) Being open and available to the general public.

(2) Having regularly established and posted business hours.

(3) Having adequate supplies in stock on the premises.

(4) Meeting all local laws and ordinances regarding business licensing and operations.

(5) Having the necessary equipment and facilities to carry out day-to-day business for his or her practice.

(b) An unannounced visit pursuant to subdivision (a) shall be prohibited with respect to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless the department has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

(c) Failure to remediate significant discrepancies in information provided to the department by the provider or significant discrepancies that are discovered as a result of an announced or unannounced visit to a provider, for purposes of enrollment, continued enrollment, or certification pursuant to subdivision (a) shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program. The director shall notify in writing the provider of the temporary suspension and deactivation of provider numbers, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions in this paragraph shall be in accordance with Section 14043.65.

(d) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Section 455.416 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 23. Section 14043.75 of the Welfare and Institutions Code is amended to read:

14043.75. (a) The director may, in consultation with interested parties, by regulation, adopt, readopt, repeal, or amend additional measures to prevent or curtail fraud and abuse. Regulations adopted, readopted, repealed, or amended pursuant to this section shall be deemed emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). These emergency regulations shall be deemed necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted, amended, or repealed pursuant to this section shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(b) Notwithstanding any other ~~provision of~~ law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific Sections 14043.15, *14043.25*, 14043.26, 14043.27, 14043.28, 14043.29, and 14043.341 by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific those provisions described in this subdivision, including all of the following:

(1) Notifying provider representatives of the proposed action or change. The notice shall occur at least 10 business days prior to the meeting provided for in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the action or change.

(3) Allowing for written input regarding the action or change.

(4) Providing at least 30 days' advance notice of the effective date of the action or change.

SEC. 24. Section 14107.11 of the Welfare and Institutions Code is amended to read:

14107.11. (a) Upon receipt of ~~reliable evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, of fraud or willful misrepresentation by~~ *a credible allegation of fraud against* a

provider as defined in Section 14043.1, under the Medi-Cal program or the commencement of a suspension under Section 14123, the *provider shall be temporarily placed under payment suspension, unless it is determined there is a good cause exception, as defined in subdivision (g), not to suspend the payments or to suspend them only in part, and the* department may do any of the following:

(1) Collect any Medi-Cal program overpayment identified through an audit or examination, or any portion thereof from any provider. Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170). Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings if the findings are against the provider. Overpayments will be returned to a provider with interest if findings are in favor of the provider.

(2) ~~Withhold payment~~ *Give notification of the payment suspension* for any goods, services, supplies, or merchandise, or any portion thereof. The department shall notify the provider within five days of any ~~withholding of~~ payment *suspension* under this section. *The department may delay notification to the provider by 30 days if it is requested to do so in writing by any law enforcement agency, which may be renewed in writing up to two times and in no event may exceed 90 days.* The notice *to the provider* shall do all of the following:

(A) State that ~~payments are being withheld~~ *the payment suspension is being imposed* in accordance with this subdivision and that the ~~withholding~~ *payment suspension* is for a temporary period and will not continue ~~after~~ *if* it is determined that ~~the evidence of fraud or willful misrepresentation is insufficient~~ *no credible allegation of fraud remains against the provider* or when legal proceedings relating to ~~the alleged fraud or willful misrepresentation~~ *the allegation* are complete.

(B) Cite the circumstances under which the ~~withholding of the payments~~ *payment suspension* will be terminated.

(C) Specify, when appropriate, the type or types of claims for which payment is being ~~withheld~~ *suspended*.

(D) Inform the provider of the right to submit written evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, for consideration by the department.

~~(3)~~

(b) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a ~~withholding of~~ payment *suspension* pursuant to Section 14043.65. Payments ~~withheld~~ *suspended* under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings.

(c) A payment suspension may be lifted when a resolution of an investigation for fraud or abuse occurs as defined in subdivision (p) of Section 14043.1.

(d) An allegation shall be considered credible if it exhibits indicia of reliability as recognized by state or federal courts or by other law sufficient to meet the constitutional prerequisite to a law enforcement search or seizure of comparable business assets.

(e) On a quarterly basis, the Department of Justice, and any other law enforcement agency that has accepted referrals for investigation from the department, shall submit a report to the department listing each referral and stating whether the referral continues to be under investigation and whether it involves a credible allegation of fraud. If the Department of Justice or a law enforcement agency fails to submit a report under this subdivision, the department may request the report from the Department of Justice or the law enforcement agency on no more than a quarterly basis. The Department of Justice or the law enforcement agency, as applicable, shall provide the report within 30 days of the request.

(f) A report, request, or notification submitted under this section shall be exempt from the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). These records may be disclosed to law enforcement agencies or other government entities that execute an agreement conforming to subdivision (e) of Section 6254.5 of the Government Code.

(g) For purposes of this section, all of the following apply:

(1) "Provider" has the same meaning as that term is defined in Section 14043.1

(2) "Good cause exception" means a reason determined by the department that falls under Section 455.23(e) or (f) of Title 42 of the Code of Federal Regulations.

(3) "Law enforcement agency" includes any agency employing peace officers, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code.

~~(b)~~

(h) The director may, in consultation with interested parties, adopt regulations to implement this section as necessary. These regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) Part 1 of Division 3 of Title 2 of the Government Code) and the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120-day duration period of emergency regulations, the director shall transmit directly to the Secretary of State the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

~~(c) For purposes of this section, "provider" means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, employees, or agents thereof, that provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary, and that has been enrolled in the Medi-Cal program.~~

SEC. 25. Section 14123.05 of the Welfare and Institutions Code is amended to read:

14123.05. The department shall develop, in consultation with provider representatives, including, but not limited to, physician, pharmacy, and medical supplies providers, a process that enables a provider to meet and confer with the appropriate department officials ~~within 30 days~~ after the issuance of a letter notifying the provider of a ~~temporary withhold of payments~~ *payment suspension*,

pursuant to Section 14107.11, or a temporary suspension, pursuant to subdivision (a) of Section 14043.36, for the purpose of presenting and discussing information and evidence that may impact the department's decision to modify or terminate the sanction.

SEC. 26. Section 14409 of the Welfare and Institutions Code is amended to read:

14409. (a) No prepaid health plan, marketing representative, or marketing organization shall in any manner misrepresent itself, the plans it represents, or the Medi-Cal program or Healthy Families Program. Violations of this section shall include, but are not limited to:

(1) False or misleading claims that marketing representatives are employees or representatives of the state, county, or anyone other than the prepaid health plan or the organization by whom they are reimbursed.

(2) False or misleading claims that the prepaid health plan is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the prepaid health plan.

(3) False or misleading claims that the state or county recommends that a Medi-Cal beneficiary enroll in a prepaid health plan.

(4) Claims that a Medi-Cal beneficiary will lose his benefits under the Medi-Cal program or any other health or welfare benefits to which he is legally entitled, if he does not enroll in a prepaid health plan.

(b) Violations of this article or regulations adopted by the department pursuant to this article shall result in one or more of the following sanctions that are appropriate to the specific violation, considering the nature of the offense and frequency of occurrence within the prepaid health plan:

(1) Revocation of one or more permitted methods of marketing.

(2) Termination of authorization for a plan to provide application assistance.

(3) Refusal of the department to accept new enrollments for a period specified by the department.

(4) Refusal of the department to accept enrollments submitted by a marketing representative or organization.

(5) Forfeiture by the plan of all or part of the capitation payments for persons enrolled as a result of such violations.

(6) Requirement that the prepaid health plan in violation of this article personally contact each enrollee enrolled to explain the nature of the violation and inform the enrollee of his right to disenroll.

(7) Application of sanctions as provided in Section 14304.

(8) Temporarily ~~withhold~~ *suspend* capitation payments for beneficiaries enrolled in violation of this article, or regulations adopted thereunder, until the prepaid health plan is in substantial compliance with the statutory and regulatory provisions.

(c) Any marketing representative who violates subdivision (a) while engaged in door-to-door solicitation is guilty of a misdemeanor, and shall be subject to a fine of five hundred dollars ($500) or imprisonment in the county jail for six months, or both.

SEC. 27. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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